STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013427	A. BUILDING: _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE NEW RICHMOND MEMORY CARE	1310 CIRCLE PINE DR NEW RICHMOND, WI 54017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/17/2023, Surveyor completed a complaint investigation and abbreviated licensing survey at Our House New Richmond Memory Care. The complaint was substantiated. Eight violations were identified. Census: 14	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a caregiver background check was completed for 1 of 4 staff reviewed. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis.	N 219		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 219	Continued From page 1 Admin. Code ch. 12, a complete CBC, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Services (DHS). On 07/17/2023, Surveyor reviewed 4 resident care assistant (RCA) files. RCA D was hired on 06/10/2020. His/her record included a BID form, dated 01/27/2021. The record did not include a DOJ or DHS report. At approximately 2:00 PM, Surveyor interviewed Executive Director (ED) A and Regional Director (RD) B. ED A stated s/he reviewed RCA D's record and could not locate a DOJ or DHS report. RD B stated s/he assumed the BID was signed over 6 months after hire because they found the error during an internal file audit. RD B said the ED at the time would have likely completed the DOJ and DHS report, but they did not have evidence of this.	N 219		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90	N 220		

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N 220	Continued From page 2 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 resident care assistants (RCA) were screened for communicable disease, including tuberculosis (TB), prior to working with residents. Findings include: The Department of Health Services publication Tuberculosis Screening and Testing: Health Care Personnel (HCP) and Caregivers (including assisted living staff) states: "Perform baseline testing for all HCP and caregivers without documented evidence of prior LTBI [latent tuberculosis] or TB disease... IGRA [blood test] or TST [tuberculin skin test] may be performed; IGRA is preferred... - If testing is positive, obtain chest x-ray and refer HCP or caregiver to provider for additional workup for TB disease. - In the absence of newly identified risks or symptoms, previous documented negative IGRA or TST results (within 12 months) may be used. - If TST is used as the baseline testing, 2-step testing is recommended for HCP and caregivers who have not had TST testing previously or have only had one negative TST test greater than 12 months ago. If 2 or more TST tests have been previously performed, all results are negative, and documentation of results is available, a one-step TST may be performed before hire." (Retrieved 2/22/2023 from	N 220		

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N 220	Continued From page 3 https://dhs.wisconsin.gov/publications/p02382.pdf) The provider is licensed to care for 15 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/17/2023, Surveyor reviewed 4 employee records. RCA D was hired on 06/10/2020. RCA D's record had no evidence s/he was screened for communicable disease. RCA E was hired on 07/06/2020. RCA E's record included evidence s/he completed a 1-step TST On 09/03/2021, over 1 year after hire. His/her record did not include evidence of other communicable disease screening. RCA F was hired on 01/20/2023. RCA F's record included evidence of a 1-step TST. RCA F's file did not include evidence s/he was screened for other communicable illnesses. At approximately 2:00 PM, Surveyor interviewed Executive Director (ED) A and Regional Director (RD) B. ED A stated s/he provided new employees a communicable disease screening questionnaire that they were responsible for filling out and bringing with them to the clinic. ED A said the healthcare professional doing the baseline TB test was supposed to review and sign the questionnaire indicating the employee was free of communicable disease. The new employee turned the communicable disease questionnaire and TB test results into the ED. Surveyor asked what kind of TB baseline testing they required. ED A and RD B stated they followed the recommendation of the local clinic. Neither	N 220		

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N 220	Continued From page 4 manager was aware they needed to obtain 2 TSTs or a blood test.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 resident care assistants (RCA) sampled completed orientation training prior to assuming job duties. Findings include: The provider is licensed to care for 15 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/17/2023, Surveyor reviewed 4 employee records. RCA E was hired on 07/04/2020. RCA E's record included evidence that s/he completed abuse and neglect training on 11/19/2020, over 4 months after hire. His/her record did not include evidence of training on emergency procedures or	N 230		

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N 230	Continued From page 5 recognizing and responding to changes in condition. At approximately 2:00 PM, Surveyor interviewed Executive Director (ED) A and Regional Director (RD) B. ED A stated s/he reviewed RCA E's record and could not locate orientation training. RD B reviewed RCA E's record and stated did not find evidence of orientation training either.	N 230		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 caregivers sampled completed continuing education. Resident Care Assistant (RCA) D did not complete continuing education in 2021 or 2022. RCA E did not complete continuing education in 2022. Findings include: The provider is licensed to care for 15 residents	N 277		

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N 277	Continued From page 6 in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/17/2023, Surveyor reviewed employee records. RCA D was hired on 06/10/2020. RCA D's record included 7 hours of continuing education in 2021 and no training hours in 2022. RCA D's 2021 training did not include refreshers on resident rights, abuse and neglect, or fire safety and first aid. RCA E was hired on 07/06/2020. RCA D's record included 12 hours of training in 2022. RCA D did not complete trainings on standard precautions, medications, resident rights, or abuse and neglect in 2022. At approximately 2:00 PM, Surveyor interviewed Executive Director (ED) A and Regional Director (RD) B. RD B stated the provider used an online system for continuing education since April 2022. Prior to this, trainings were recorded and maintained in the employee's hard file. RD B said the ED was responsible for ensuring employees completed training requirements. RD B reviewed RCA D's and RCA E's electronic and hard-copy records and did not find additional continuing education training documentation.	N 277		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review, and	N 388		

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N 388	Continued From page 7	N 388		

interview, the provider did not ensure Resident 1's individual service plan (ISP) was implemented. Resident 1 was not provided incontinence care on 07/17/2023 per his/her ISP.

Findings include:

On 05/30/2023, the Department received a complaint related to resident care.

On 07/17/2023 at 9:03 AM, Surveyor observed Resident Care Assistant (RCA) C and RCA G perform morning cares on Resident 1. The RCAs changed, washed, and dressed Resident 1 while s/he lied in bed. At 9:20 AM, RCA C and RCA G transferred Resident 1 to his/her Broda chair and Resident 1 stated s/he needed to go to the bathroom. RCA G and RCA C encouraged Resident 1 to void and stated they would change him/her when s/he was done. Resident 1 stated s/he was done voiding, and RCA C stated they would change Resident 1 after breakfast. At 9:30 AM, RCA G brought Resident 1 to the dining room. Surveyor observed Resident 1 in the dining room until 11:26 AM when staff brought Resident 1 back to his/her room.

At 11:26 AM, while in Resident 1's room with RCA D and RCA G, Surveyor asked if Resident 1 received incontinence care since the morning observation. RCA D stated s/he had not. Surveyor observed that Resident 1 had soiled and wet through his/her incontinence brief and pants and required a shower. RCA D stated Resident 1 was on a 2-hour toileting schedule, but it was typical for him/her to wet through his/her brief during this time.

Surveyor reviewed Resident 1's record. Resident 1 was admitted on 06/28/2022. His/her ISP, dated

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N 388	Continued From page 8 07/14/2023, read: "Personal Hygiene/Continence...Always needs assistance with toileting, getting on and off toilet, or with related hygiene/incontinence products...Staff to monitor to make sure resident remains dry at all times...Team Member will provider peri-care after each time resident is incontinent. Team Member to assist resident in changing incontinent product when soiled and as needed."	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 1's individual service plan (ISP) was updated when his/her condition changed. Findings include: On 05/30/2023, the Department received a	N 389		

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N 389	Continued From page 9	N 389		

complaint related to resident care.

On 07/17/2023 at 9:03 AM, Surveyor observed Resident Care Assistant (RCA) C and RCA G perform morning cares on Resident 1. The RCAs changed, washed, and dressed Resident 1 while s/he lied in bed. Surveyor asked if Resident 1 used the toilet and RCA C stated s/he was unable to use the toilet due to unsteadiness. Resident 1 required full assistance from both staff during all observed tasks, including repositioning and transferring.

At 11:26 AM, Surveyor observed RCA D and RCA G transfer Resident 1 from Broda chair to bed and perform incontinence care. Resident 1 did not assist in the task and required constant verbal reassurance from staff.

Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/28/2022 and admitted to hospice on 12/29/2022. Resident 1 was hospitalized from 1/10/2023 through 01/15/2023 due to a fall that resulted in a hip surgery. On 02/22/2022, Resident 1's hospice team ordered 2-hour repositioning. On 03/20/2023, hospice ordered a pureed diet.

Resident 1's ISP, dated 07/14/2023, read: "Mobility and Walking - Assistance... 1 person(s) required for this task. Please assist resident with walking to and from bathroom in the morning and evening. **PRN** (as needed) If resident has energy staff can assist with walk [sic] from [his/her] bedroom to the couch. Please be aware if resident is tired or more anxious and do a different time. Please note in observations when and how far [s/he] walks... (2/15/2023) Team members will walk resident with walker and full assistance to and from [his/her] bathroom twice

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N 389	Continued From page 10 daily and as needed to the dining room. Family is in agreement... Resident will reposition and transfer out of bed safely through next assessment... (1/1/2023) Resident received an order for a hospital bed... Resident has returned from the hospital with a slight decline in ambulation and mobility. The quarter rail will be used to aide [sic] the resident in repositioning in [his/her] bed. Team members will encourage resident to use the railing when moving in and out of bed... Fall Risk Monitoring... (1/10/23) Resident had a fall on 1/9 in [his/her] room and was brought to the hospital. Will update stability and falls with interventions when resident returns. Team member will [sentence not finished; no intervention provided]... Dressing... 1 person(s) required for this task... (1/4/23) Resident needs full assistance choosing clothing and getting dressed and undressed. Team members will help resident pick out clothing and cue resident through dressing and assistance as needed, while promoting independence." At 12:10 PM, Surveyor interviewed Executive Director (ED) A. ED A stated s/he started in the position in April 2023. ED A said ISPs were updated quarterly or when there was a change in condition. ED A stated s/he updated Resident 1's ISP in July because it was due for a quarterly review. At 1:54 PM, Surveyor interviewed RCA D. RCA D stated Resident 1 was not able to reposition him/herself and had not been on a walking program since the beginning of the year.	N 389		

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N 441	Continued From page 11	N 441		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and record review, the provider did not ensure all employees followed hand washing procedures according to the Center for Disease Control and Prevention (CDC) standards. Resident Care Assistant (RCA) C, RCA G, and RCA D did not perform hand hygiene during Resident 1's personal care on 07/17/2023. Findings include: The CDC recommends hand hygiene to be performed: "- Immediately before touching a patient - Before performing an aseptic task or... handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal... Gloves are not a substitute for hand hygiene....If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment...Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if - gloves become damaged,	N 441		

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N 441	Continued From page 12 - gloves become visibly soiled with blood or body fluids following a task, - moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs." (Source: https://www.cdc.gov/handhygiene/providers/index.html, retrieved 07/19/2023) The provider is licensed to care for 15 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/17/2023 at 9:03 AM, Surveyor observed RCA C and RCA G perform morning cares on Resident 1. The tasks included undressing, changing his/her incontinence brief, peri-care, dressing, teeth brushing, and application of makeup. RCA C and RCA G each donned 1 pair of gloves throughout the observation and did not doff them until after Resident 1 was dressed, seated in his/her Broda chair, and ready to be assisted to the dining room. Neither staff performed hand hygiene before donning or after doffing their gloves. At 1:54 PM, Surveyor observed RCA D and RCA G transfer Resident 1 to his/her bed and perform incontinence care. Both caregivers donned gloves prior to beginning the task and did not remove them or perform hand hygiene when moving from a soiled body site to a clean body site. While changing Resident 1, RCA D determined Resident 1 required a shower. RCA G left Resident 1's room to get the house shower chair. RCA G did not remove the gloves or perform hand hygiene before leaving the room.	N 441		

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N 526	Continued From page 13	N 526		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 emergency evacuation drills (other than fire drills) were completed in 2021 and 2022. Findings include: The provider is licensed to care for 15 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 07/17/2023, Surveyor reviewed the provider's evacuation drills for 2021 and 2022. Documentation indicated 1 severe weather drill was performed per year. No other evidence of emergency evacuation drills (other than fire drills) were found. At approximately 2:00 PM, Surveyor interviewed Executive Director (ED) A and Regional Director (RD) B. ED A stated s/he started in April 2023 and s/he could only find evidence of 1 "other" evacuation drill per year. RD B stated s/he would review the records and send additional documentation to Surveyor by the end of the day. As of 07/18/2023, Surveyor did not receive additional documentation.	N 526		